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ABSTRACT

Self-disclosure (SD) is considered an important part of psychotherapy and an essential ingredient of psychological health. The difference between self-reported SD (how much a patient said he disclosed) and observed SD (how much a therapist said the patient disclosed) was investigated to examine the effects on psychotherapy outcome. Adult psychiatric inpatients (N=43) were divided into therapy groups of six to 10 patients meeting eight times in a two-week period. Patients completed the Group Therapy Self-Disclosure Questionnaire and observers rated self-disclosure using the Rating Scale Guideline. Results indicated that self-reported SD measures were not valid instruments to assess the SD of certain patients. Subjects were divided into three categories of SD discrepancy: overraters, concordants, and underraters. Overraters also overrated their own outcome. Underraters and concordants agreed with the therapists about their outcomes. Underraters and concordants were most likely to be neurotic and depressed, while the overraters were more likely to be psychotic. (NRB)

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Discrepancy Between Self-Reported Self-Disclosure and Actual Self-Disclosure and Its Relationship to Group Psychotherapy Outcome

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Discrepancy Between Self-Reported Self-Disclosure and Actual Self-Disclosure and Its Relationship to Group Psychotherapy Outcome

The purpose of this study was to examine the discrepancy between self-reported self-disclosure (SD) and observed self-disclosure and their relationship to group psychotherapy outcome. Essentially, we studied the difference between how much a patient said (s)he self-disclosed in a therapy group and how much an observer or therapist said (s)he self-disclosed. We then examined the way in which this difference was related to group psychotherapy outcome.

In the late 1950's Sidney Jourard described self-disclosure or SD as the amount of personal information that one person is willing to relate to another. He said it is based on the degree of intimacy involved in the interpersonal interaction. He emphasized the importance of self-disclosure in maintaining psychological health and fostering personal growth. Allen (1973) asserts that for any form of psychotherapy a patient must reveal him/herself to the therapist. Specifically Allan contends that in group psychotherapy certain "curative factors" could not occur without SD.

Self-disclosure appears to be related to optimal adjustment in a curvilinear way: Too little SD and too much SD both seem to be a manifestation of maladaptive interpersonal behavior.

In psychotherapy outcome research, a clear-cut relationship regarding SD and outcome has not been agreed upon. Coché and Polikoff (1979) suggest that this may be partially due to the type of instrumentation used to measure SD.

Since the systematic study of SD began in 1959, most SD investigations have used a self-report measure called the Jourard Self-Disclosure Questionnaire. However, self-report measures have been criticized for their lack of predictive validity. More recently, therefore, observer-rated scales have been developed to quantify actual self-disclosing behavior.

Hurley and Hurley (1969) examined the relationship between self-report SD measures and observer measures. They found that subjects were often in considerable disagreement with the observed measures of self-disclosure. Weigel and Warnath (1973) stressed that the method of eliciting ratings of SD actually involves SD itself. Therefore, people who are poor assessors of their own SD are not self-disclosing very well. Our hypothesis was that these poor assessors were likely to have a poor outcome in their group psychotherapy.

The investigation reported here focused on self-reported self-disclosure and observed self-disclosure in group psychotherapy. We examined the relationship between both types of measures and psychotherapy outcome. A major hypothesis was that patients whose self-reported SD score agreed with their observed SD score would exhibit a higher improvement score on an outcome measure than patients whose self-reported SD score disagreed with the observed SD score. In other words: People who have discrepant scores are likely to have poor outcomes. People who have concordant scores are likely to have better outcomes. In addition, those patients who have high SD scores were expected to improve more than those who had lower SD scores.

The subjects were 43 adult psychiatric inpatients at Friends Hospital. They were recommended by their attending physicians for group psychotherapy and before joining were evaluated by the co-therapists who led the group.

The intervention consisted of 8-session psychotherapy groups conducted within a two-week span. They were run by two co-therapists whose styles were similarly humanistic and behavioral in approach. The groups consisted of 6-10 patients. The co-therapists were a Ph.D. staff psychologist and another staff member of the Psychology Department at Friends Hospital.

The self-report measure used to rate self-disclosure was the Group Therapy Self-Disclosure Questionnaire developed by Pastushak. For observer rated self-disclosure, a self-disclosure Rating Scale Guideline was developed, based on ideas proposed by Dies. This scale was used by observers and co-therapists in measuring observed SD.*

The findings and their implications will be presented in three stages. First, we will look at how well the measures that purported to measure the same thing actually agreed with each other. That is, were all the SD measures in agreement, and were all the outcome measures in agreement?

Next, we will examine the relationship between self-disclosure and outcome.

Finally, we will study the discrepancy factor mentioned earlier and its relationship to outcome.

Beginning with those measures which were supposedly measuring the same thing, Figure 1 illustrates the results. On the top half of the chart, the three possible relationships between self-disclosure ratings are represented. These are the relationships between therapist and observer, therapist and patient and between observer and patient.

The ratings of therapists and observers correlated with each other at a significance level of .001 on all of the three

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*We would like to thank Susan Stein and Joe Sillitti for their conscientious work as observers and their contributions in developing the scale.

subvariables analyzed. The therapist and patient ratings of self-disclosure did not correlate significantly on any of the four variables analyzed. Thirdly, the agreement between observers and patients was studied separately for 12 variables, only two of which correlated significantly; these were at the .01 level and in the positive direction.

Because of the agreement between therapists and observers we were fairly confident about the reliability of our instruments in objectively rating SD. However, patient or self-reported SD does not appear to be a good measure of self-disclosure.

The bottom half of Figure 1 represents the relationships between the outcome ratings conducted in this study. We found that the patient and therapist ratings of outcome were correlated at the .001 significance level. Thus, the reliability of the outcome measure appears quite positive.

In the second part of the analysis we looked at the relationship of self-disclosure to outcome. In this regard, the findings of a recent study done at the same hospital (Coché, Polikoff & Cooper, 1980) suggest that psychotherapy groups composed of both neurotic and psychotic patients would lead to low or zero correlations between self-disclosure and outcome. They suggest that high SD levels lead to better outcome among the less disturbed but worse outcome among more disturbed

patients. Therefore, we would not expect much of a correlation between self-disclosure and outcome. Figure 2 illustrates our findings. SD as rated by patients and SD as rated by observers did not correlate significantly with either of the two outcome measures (i.e. patient rated or therapist rated). However, therapist rated self-disclosure did correlate at the .001 level but only with therapist rated outcome. This could potentially be due to a halo effect; it may be that those patients who were rated high on SD were likely to be rated high on outcome by the therapists. However, the observer rated SD measures, though not significant, also point in the direction of a positive link between SD and outcome in this sample.

The last part of our analysis examines the relationship between discrepancy and outcome. Overall, we found that discrepant patients who overrate their own self-disclosure also overrate their own outcome. Patients who said they self-disclosed more than the therapists or observers reported they did, also said that they had a better outcome than the therapists reported them to have. Before we study the data in this regard, it appears desirable though to point out that the likelihood of finding a significant relationship when comparing discrepancy to outcome is very small. This is due

to the fact that discrepancy was not measured directly and neither was outcome. Rather, both resulted from comparing two other scores, namely, pre versus post for outcome and self versus other for discrepancy. Thus, the potential error sources were quadrupled.

What we had expected to find was a negative relationship between discrepancy and outcome. That is, we expected that the greater the difference between patient rated SD and observer or therapist rated SD, the smaller the improvement would be. We found a significant relationship and at the .01 level but it was in an unexpected direction: Those patients who had discrepant SD scores had better self-reported outcome than concordant patients. These patients did not however have a better therapist rated outcome than the concordant patients. Figure 3 will help visualize it.

In Figure 3, self-reported SD on the one hand is compared to either therapist or observer rated SD on the other hand. The resulting groups of patients could be separated into three groups. There were those patients who underrated their own SD, a second group consistently agreed with observers and therapists when they rated their SD, a third group was comprised of those patients who over-rated their SD, i.e. those who said they self-disclosed more than the therapist or observers said they did.

Although we do not have the evidence, we can speculate that the first two groups (the underraters and the concordants) mostly likely consisted of neurotic and depressed patients while the last group the overraters most likely consisted of psychotic patients. Comparing these three groups in their outcome, one finds that the concordant group and the underraters showed concordance between the self-rated outcome and the outcome as rated by the therapists. However, the overraters not only were discrepant in their SD ratings but were also significantly discrepant between self-reported outcome and therapist reported outcome.

We may thus have identified one of the factors that contributes to the discrepant findings in the literature. Apparently self-reported SD measures are not a valid instrument for certain patients to assess their self-disclosing. Overraters, i.e. those patients who consistently overestimate their self-disclosure levels in their self-reports, also overestimate their own improvement. These may very well be the same psychotic patients for whom Coché, Polikoff and Cooper suggest that SD may not be conducive to successful therapy outcome. Thus, some of the discrepant findings also discovered by Hurley and Hurley may be explained by this group of subjects who confound the relationship between self-disclosure and outcome through their behavior. Further, our results point to advisability

of separating out the overraters prior to or early in group therapy. A discrepancy measure could be a useful discriminating tool. These patients could then be provided with an experience that is more conducive to a positive outcome than a psychotherapy group which presses for self-disclosure. The remaining patients would be those that were likely to benefit from self-disclosure and the relationship between self-disclosure and group psychotherapy outcome would be more straightforward.

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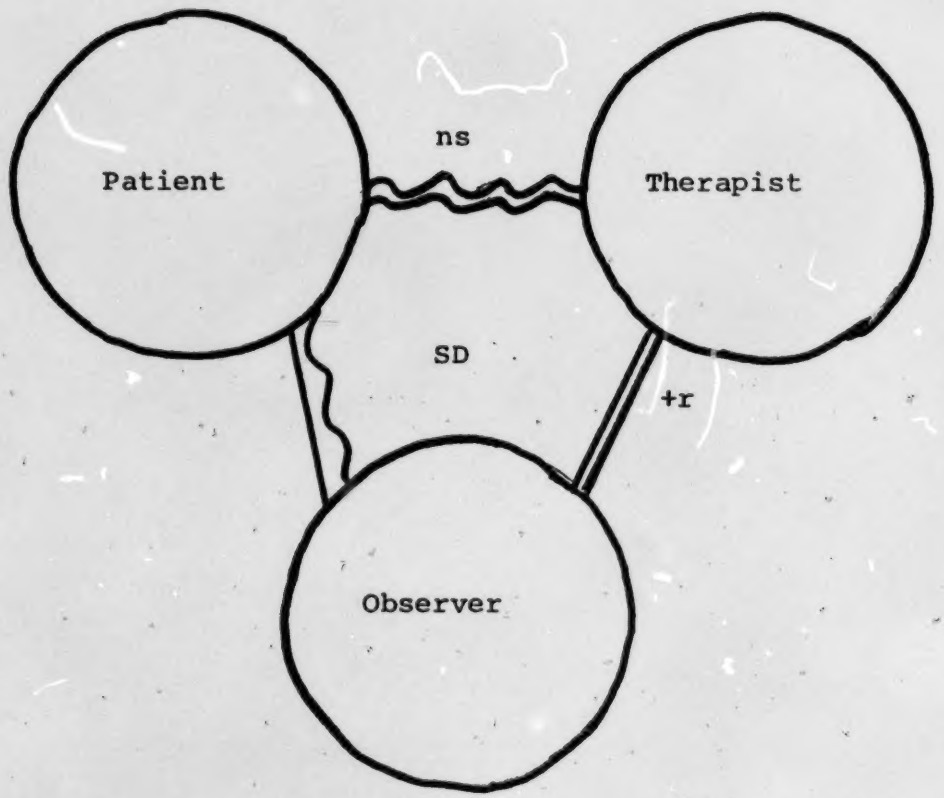
Figure 1



OUTCOME

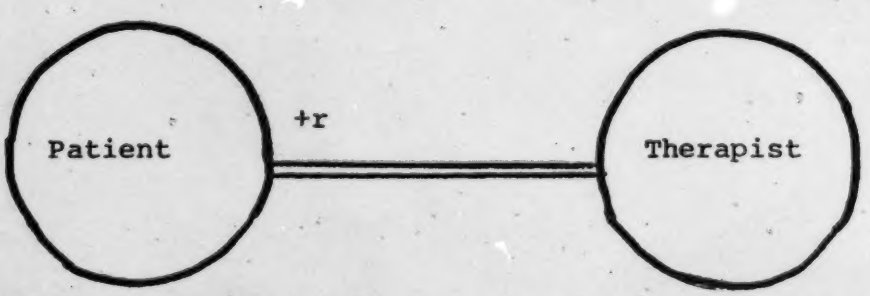


Figure 2

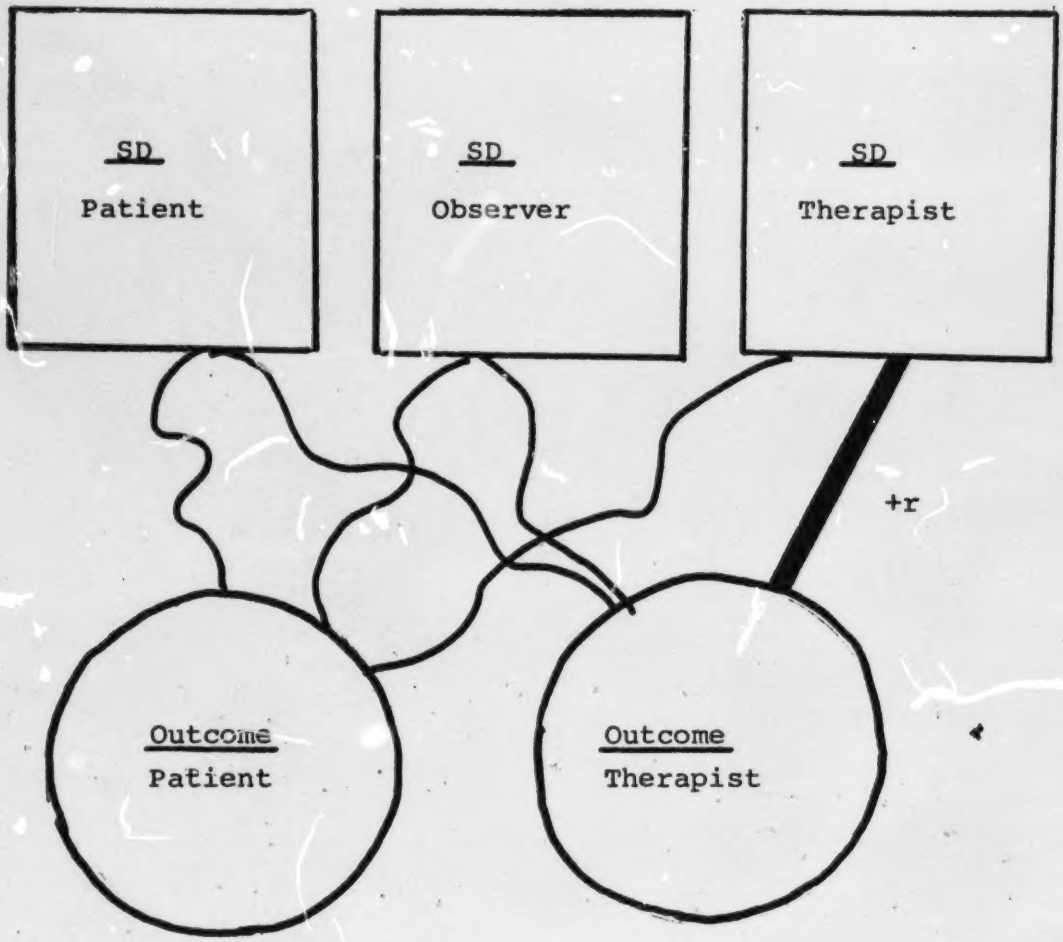
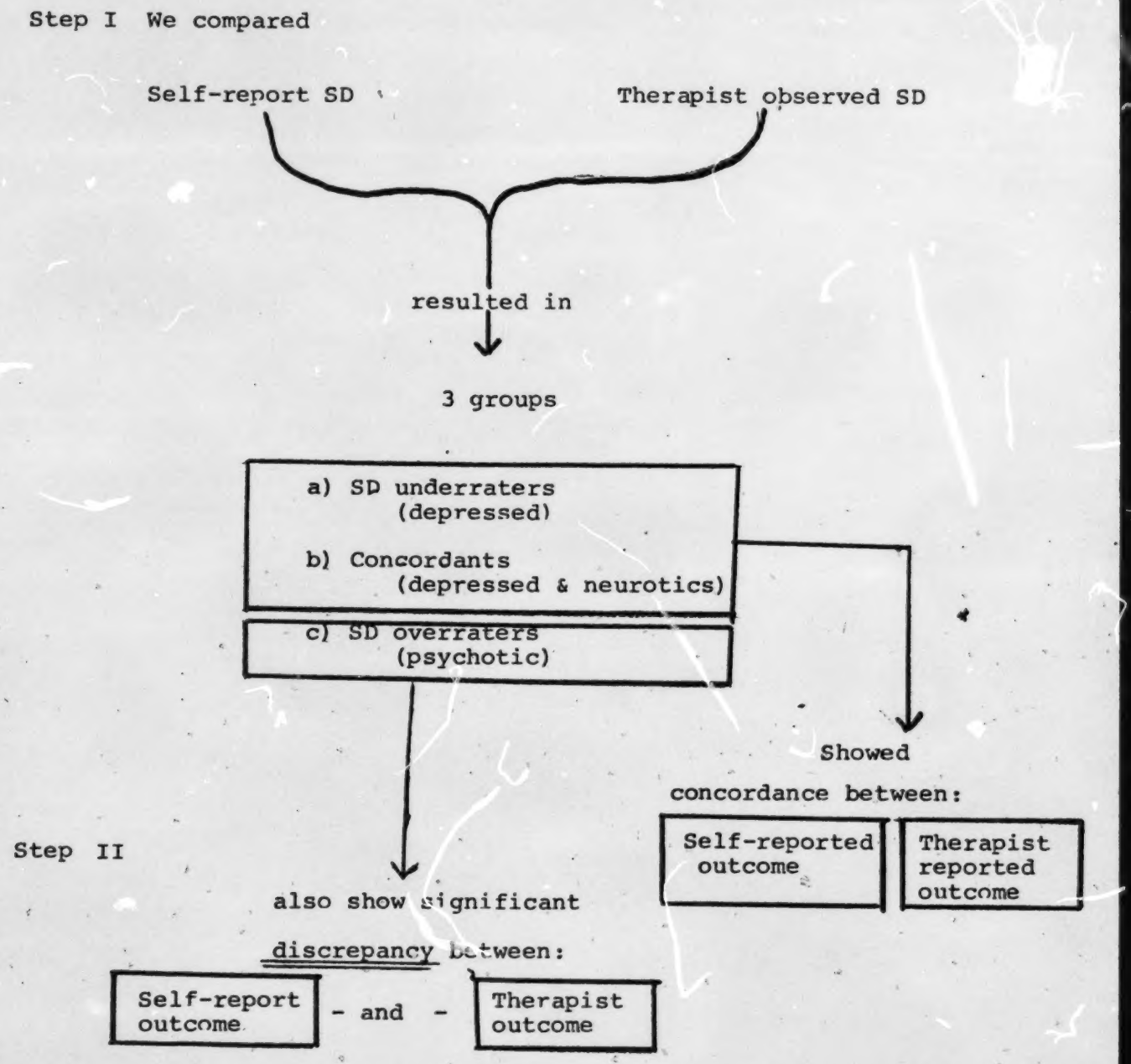

SD
Patient
SD
Observer
SD
Therapist
+r
Outcome
Patient
Outcome
Therapist

Figure 3


Step I We compared
Self-report SD
Therapist observed SD
resulted in
3 groups
a) SD underraters (depressed)
b) Concordants (depressed & neurotics)
c) SD overraters (psychotic)
Showed concordance between:
Self-reported outcome
Therapist reported outcome
Step II
also show significant discrepancy between:
Self-report outcome
- and -
Therapist outcome